FACT SHEET COUNTING FATAL CHILD ABUSE AND NEGLECT RESULTS OF CALIFORNIA RECONCILIATION AUDIT, 1997

I. Problem statement

- Child abuse and neglect (CAN) remains a serious societal problem in California.
- Fatal CAN is the most extreme consequence of CAN.
- Fatal CAN represents the number one cause of injury deaths for infants and the 2nd leading cause of death for the 1-4 and 5-12 year old group behind drowning.
- The true incidence of fatal CAN, however, is not known (National estimates range from 1,000 2,600 child deaths per year).
- There are serious ascertainment and surveillance problems with existing data sources.
- Information is needed in order to develop more effective policies and interventions.

II. Creating solutions in California

- State and local child death review teams (CDRTs) formed
- California efforts

Local CDRTs review child deaths

State Child Death Review Council oversees statewide training and data collection

III. Report of California Reconciliation Audit for 1997

A. Purpose

- Describe the true incidence of fatal child abuse and neglect in California
- Produce an annual report on Reconciliation Audit results (Started with 1996 data)
- Determine the proportion of fatal CAN missed in each of the existing data systems
- Describe available demographic characteristics of fatal CAN cases

B. Methodology

- Design: Reconciliation Audit of all 1997 child deaths (< 18 years of age) recorded as CAN in three statewide data sources conducted by local CDRTs based on local case identification, reviews and classification.
- Data sources:

Department of Health Services Vital Statistics Death Records (VSDR)

Department of Justice Homicide File (DOJ HF)

Department of Justice Child Abuse Central Index (DOJ CACI)

Local CDRTs case reviews

Sample:

Identified 1997 fatal CAN cases recorded in three statewide databases

Data Source	Number
VSDR	33
DOJ HOM	105
DOJ CACI	<u>47</u>
TOTAL	138 Unique Cases
	+25 CAN deaths identified by local CDRTs
	163 Unique CAN deaths identified by at least one source

B. Methodology (continued)

• Audit questions posed for the CDRTs to answer about each case:

Was the Team aware of this case?

Did the Team review this case?

Did the Team call the death a homicide?

Did the Team call the death a CAN homicide?

Did the Team identify and call any other deaths a CAN homicide?

IV. Results

A. Identification of fatal CAN cases

1. Fatal CAN cases identified from merging three statewide databases (N=138)

Data Source	Unique	In Two	In All Three	TOTAL
	Cases	Databases	Databases	Cases
VSDR	7	19	7	33
DOJ HOM	67	31	7	105
DOJ CACI	24	16	7	<u>47</u>
Unique Totals	98 (71%)	33 (24%)	7 (5%)	138 (100%)

3. Fatal CAN cases identified and reviewed by local CDRTs

Local CDRT aware of state database cases: Unique cases ID'ed by local CDRTs:	121 of 138 (88%)
TOTAL – Aware:	146 of 163 (90%)
TOTAL – Reviewed:	139 of 163 (85%)

B. Determination of "true" incidence of fatal CAN:

Fatal CAN cases confirmed by CDRTs (State sources)	98/138 (71%)
Fatal CAN cases confirmed by CDRTs (State & CDRT sources)	123/163 (75%)

C. Sensitivity and Specificity using local CDRTs as the "gold standard" for Fatal CAN

Test Accuracy For Each Source	Sensitivity ¹	Specificity ^{2a} (N=146)	Specificity ^{2b} (N=163)
VSDR	29/123 24%	21/23 91%	36/40 90%
DOJ HOM	86/123 70%	15/23 65%	21/40 53%
CACI	26/123 21%	9/23 35%	19/40 48%

Sensitivity refers to the proportion of fatal CAN cases correctly classified in each data source compared to the standard, i.e., cases confirmed by the local CDRTs.

D. Estimated number of CAN Fatalities based upon the 1997 Audit

Cases confirmed by local CDRTs Audit	123
Estimate of cases among non-reviewed cases (n=34)	<u>12</u>
CALCULATED TOTAL FATAL CAN – 1997	135

² Specificity refers to the proportion of cases that were not fatal CAN that were correctly classified in each data source compared to the standard, i.e., cases not confirmed as fatal CAN by the local CDRTs.

^a Specificity calculated on cases reviewed by CDRTs.

b Specificity calculated on cases identified by any source.